



Send claim submissions to:
claims@rmts.net
or
Claims Department
RMTS, LLC
6 Harrison St
New York, NY 10013
212-925-8760 (fax); 212-925-0017 (phone)

CLAIMS KIT **STOP LOSS CLAIMS PROCEDURE**

Please submit claims as soon as the stop loss deductible has been exceeded to the address listed below. In order to process your claim, it is necessary that the following be submitted:

- A. Completed reimbursement request form (Attachment A for specific claims; Attachment D for aggregate claims);
- B. Copy of the enrollment form or card as described in Section I below;
- C. Completed Eligibility Verification form for claims over \$250,000 or claimants over the age of 65 as described in Section II below (see instructions (Attachment B) and form (Attachment C)); *We reserve the right to require the Eligibility Verification form outside these guidelines.*
- D. COBRA election form, if applicable as described in Section II below;
- E. Verification of COBRA premium payments, if applicable as described in Section II below;
- F. If claimant is a dependent, verification of other coverage as described in Section III below;
- G. Copy of Medicare Card if claimant is eligible for Medicare as described in Section IV below;
- H. Verification and results of Preexisting review or Certificate of creditable coverage, if applicable as described in Section V below;
- I. Paid claim report or spreadsheet for claim submitted as described in Section VI below;
- J. Copies of all bills over \$1,000 and a detailed itemization for bills over \$25,000 as described in Section VII below; *Proof of Funding may be requested on certain bills.*
- K. EOBs or an acceptable system-generated paid claims report as described in Section VII below;
- L. Applicable correspondence (Precertification verification, R & C determinations, audit results, case management, admit/discharge statement, workers compensation info, accident details, subrogation, third party liability) as described in Section VIII below;
- M. If prescription drug card coverage is included for stop loss reimbursement, supporting documentation of these charges will be required as described in Section IX below;

CLAIM REVIEWS

As part of the claim review process, a claim audit is conducted. This audit verifies employee/claimant disclosure, if applicable, eligibility and appropriateness of claim payment according to the terms of the underlying Plan document. Reimbursements are made subject to all terms and provisions outlined in the specific stop loss contract. Potential information for a claim review is listed below. If we do not receive the requested information, it may result in the delay, reduction or denial of a claim.

I. Enrollment Card/Change Forms

- *A copy of the enrollment card and any subsequent change forms.* Most plans require employees and dependents to enroll within specific periods of time to be eligible for coverage. In order to verify that appropriate enrollment procedures were followed, this information is required. In addition, your plan may have unique provisions therefore please include any supporting documentation that will verify such provisions were followed. If claimant is a dependent and enrollment card is more than 2 years old, a recent enrollment card is required;

II. Employee Status

- *Verification must be provided that the employee met and continues to meet all eligibility requirements of the underlying Plan.* Most plans contain specific provisions regarding waiting periods, hourly requirements and continuing eligibility in the event of lengthy absence. We require verification that the claimant met and continues to meet the plan provisions. The attached Eligibility Verification form must be completed and attached to all claim submissions for claims over \$250,000 in excess of the specific stop loss deductible (including those filed for dependents) or for claimants over age 65. Documentation may also be required that shows the amount of accrued vacation/sick time/FMLA available/used by an employee in the event of a lengthy absence. We reserve the right to require such additional documentation, including the Eligibility Verification forms for claims under \$250,000, as might be necessary for us to determine eligibility under the terms of the plan and Stop Loss Contract.
- *If an employee is continuing eligibility due to COBRA, the COBRA election form and supporting documentation of premium payments will be required.* COBRA continuation is usually permitted once the employee or dependent makes a valid election and remits premium within a timely manner. Documentation supporting the plan provisions were followed in regard to these provisions will be required.
- *Documentation supporting the receipt of premium payments is required whenever the employee is responsible for remitting premium payments.* Many plans require the employee to pay premium payments during any type of leave or retirement. If such payments are required by the underlying Plan, documentation that supports the plan provisions were met will be required.

III. Dependent Claims

- **Verification of other coverage.** If the claim is filed for a dependent, verification of other coverage will be required. If other insurance does exist, a copy of the other Plan may be required to establish the primary/secondary payor.
- **Verification of dependent eligibility.** Most plans provide coverage only for those dependents eligible as defined by the plan provisions. To determine if a claimant meets the underlying provision, additional information may be required.
 - ◆ If the last name of the claimant differs from the employee, a marriage certificate or birth certificate may be required.
 - ◆ If the claimant is an over age dependent, documentation will be required to support continued coverage under the underlying Plan. Typically this is documentation of student status and/or disabled dependent.

IV. Medicare

- **If the claimant is eligible for Medicare a copy of the Medicare card will be needed.** Most plans have specific provisions regarding the consideration of Medicare benefits. This is particularly important if the claimant is receiving dialysis, as such the first date of dialysis treatment may be required to determine primary status.

V. Pre-Existing Conditions

- **Supporting documentation of pre-existing condition reviews may be required.** Many underlying Plans have limitations regarding pre-existing conditions. If a possible pre-existing condition exists, verification that a pre-existing review was completed and the results of any such review will be needed. If creditable coverage exists, a copy of the certificate of creditable coverage will be required.

VI. Claim Payment

- **A system-generated report is needed for each claim submitted.** As payments and adjustments are done routinely, claim reports are required to ensure all claims have been submitted for review. This report should include:
 - ◆ claim number
 - ◆ provider name
 - ◆ service date
 - ◆ billed amount
 - ◆ paid amount
 - ◆ check number and date paid
 - ◆ refunds or voids received

A system-generated report must contain additional information (as described below) if it is to be accepted in lieu of EOBS.

VII. Bills/EOBs

- **Copies of the bills over \$1,000 with a detailed itemization over \$25,000, superbills, etc. and explanation of benefit statements (EOBs) are required as part of the review process.** If submitted charges include electronic claims, these claims must be identified as 'electronic claims.' If submitted bills include state mandated surcharge payments; documentation of such payments will be required prior to reimbursement consideration. This would include check numbers and payment dates. A system-generated paid claims report may be accepted in lieu of EOBS if it contains the following fields:
 - Claim number

- Date of service (To and From)
- Procedure code
- Date Bill Received by TPA
- Billed amount
- Allowed amount
- Ineligible amount and explanation reason
- Paid amount for each service billed
- Total amount paid for the claim
- Date paid
- Check number
- Voids or adjustments completed

VIII. Third Party Liability/Subrogation

- ***Signed subrogation letters/reimbursement agreement may be required due to potential third party liability.*** Most plans have specific requirements regarding potential third party liability. Most provisions include the requirement of a signed subrogation agreement/reimbursement agreement. This may be required based on plan provisions.
- ***Accident details are required for those claims that relate to an accident.*** As most plans have limitations or special provisions regarding accident related claims, detailed information may be necessary. Such details may include a written account of the accident from the claimant or a police report.

IX. Drug Card Vendors

- ***If prescription drug card coverage is included for stop loss reimbursement, supporting documentation of these charges will be required.*** If covered, the stop loss contract provides reimbursement for those charges incurred and paid within a specific time period. As with prescription drug coverage under the medical plan, the services incurred through a drug card vendor will need to include the following:
 - ◆ provider name
 - ◆ claimant name
 - ◆ fill date
 - ◆ drug name
 - ◆ dosage
 - ◆ quantity received
 - ◆ billed amount
 - ◆ paid amount

In addition verification of payment to the drug card vendor will be required. A copy of the invoice, supporting documentation of charges for the claimant billed under the invoice, check number and payment amount will need to be submitted.

X. Out-of-Contract Agreements/Administrative Agreements

- ***Any benefits paid outside of the provisions of the plan and stop loss contract are not eligible for reimbursement unless prior approval is given.*** The stop loss contract provides reimbursement for those charges eligible as indicated by the provisions of the underlying plan and stop loss contract. Circumstances may dictate the consideration of benefits for services not normally covered by these provisions. Any request for consideration should include medical records, treatment plan and any potential savings anticipated due to the exception.

This document is intended as guideline only. If you have a question regarding claim reviews, please contact your appropriate RMTS representative.

ATTACHMENT A
Stop Loss Claim Reimbursement Request
This form must be completed in full with ALL submissions.

Submission Number: _____ (For initial submission number = 1)
 TPA Name: _____ Phone #: _____
 Address: _____
 Prepared By: _____ Date: _____
 Group Name: _____ Policy Year: From _____ To _____
 Carrier Group Number: _____ Incurred/Paid Basis _____
 Name of Case Management Agency: _____

Required Documents Checklist:

- Copy of the enrollment form or card; If claimant is a dependent and enrollment card is more than 2 years old, a recent claim form;
- Completed Eligibility Verification form for claims over \$250,000 or claimants over the age of 65 (see instructions on the attached form);
- COBRA election form/verification of COBRA premium payments, if applicable;
- If claimant is a dependent, verification of other coverage;
- Copy of Medicare Card if claimant is eligible for Medicare;
- Verification and results of Pre-X review or Certificate of creditable coverage, if applicable;
- Paid claim report or spreadsheet for claim submitted;
- Copies of all bills over \$1,000 and detailed itemization for bills over \$25,000;
- EOBs or an acceptable system-generated paid claims report as described in Section VII;
- Applicable correspondence (Precertification verification, R & C determinations, audit results, case management, admit/discharge statement, workers comp info, accident details, subrogation, third party liability);
- If prescription drug card coverage, supporting documentation of these charges.

<u>Employee Information</u>	<u>Claimant Information</u>
Name: _____	Name: _____
SS #: _____	Date of Birth: _____
Date of Birth: _____	Relationship to Insured: _____
Hire Date: _____ Hourly or Salaried	If dependant, effective date: _____
Title: _____	Termination Date: _____
Union Employee: Yes No	Full Time Student: _____
Enrollment Date: _____	Diagnosis: _____
Termination Date: _____	Prognosis: _____
Last date worked: _____	Disabled: Yes No (please circle one)
Status: Active Retired Other: _____	Date of Death (if applicable): _____
Disabled: Yes No (please circle one)	
Return to Work date: _____	Amount Paid to Date: \$ _____
Dates on FMLA: _____	Attachment Point: (-) \$ _____
Dates of Leave of Absence: _____	Previously Requested: (-) \$ _____
Other absences (eg. sick time): _____	Amount Requested: (=) \$ _____
COBRA effective date: _____	
Date eligible for Medicare: _____	
Retirement date: _____	

Completed by: _____ Title _____ Date: _____
 Telephone Number _____ Fax Number _____
 Send to: claims@rmts.net or Claims Dep't, RMTS, LLC, 6 Harrison St., NY, NY 10013
 212-925-8760 (fax) / 212-925-0017 (phone)

ATTACHMENT B

GUIDELINES FOR COMPLETION OF ELIGIBILITY FORM

The Eligibility Verification Form must be completed and attached to all claim submissions for claims over \$250,000 in excess of the specific stop loss deductible, including those filed for dependents, or for claimants over the age of 65. We reserve the right to require such additional documentation, including the Eligibility Verification forms for claims under \$250,000, as might be necessary for us to determine eligibility under the terms of the plan and Stop Loss Contract.

- **Employee name:** Self-explanatory.
- **Social Security number:** Self-explanatory.
- **Date of Hire:** First day employee was physically at work. Original date of Insurance: Enter original date of insurance for employee. (If rehired, please submit all applicable dates.)
- **Claimant name:** Self-explanatory. (If claimant has a different last name than employee, please submit marriage certificate, birth certificate or other documentation indicating reason for different last name.)
- **Date of Birth:** Indicate the date of birth for claimant.
- **Relationship to Employee:** (i.e. spouse, child, grandchild or other) If other, please explain in detail.
- **Effective date:** Indicate the effective date of insurance for the claimant.
- **Is COBRA Applicable:** Advise if COBRA is applicable and give effective date. (If applicable, please include election form and documentation of paid premiums. Also, verification of other insurance may be need for those who are COBRA recipients.)
- **Last date employee reported to work:** Indicate the last date the employee reported to work. (This is the date the employee was last physically at work prior to any leave of absence.)
- **Has employment terminated:** Advise if employment has terminated. If so, please give date. (If rehired must give original hire date and termination date.)
- **Dates employee absent during claim period:** Advise if employee was absent at any time during claim period. If any absences complete in detail, including vacation, sick days, FMLA, short or long term disability. This section must be completed regardless of who claimant is. This information is required whether the claim submitted is for employee or dependent, as the employee must meet and maintain the eligibility requirements of underlying plan. (If any additional time is taken during the plan year, other than originally stated please advise when submitting subsequent submissions.)
- **Employee had no absences:** Check box if employee had no absences during this claim period. (If this information changes during course of claim period, please advise when submitting subsequent submissions.)
- **Employer signature:** Signature of employer representative.
- **Title:** Signer's current title.
- **Name of Group and date form completed:** Self-explanatory
- **Name of Group Administrator:** Self-explanatory

ATTACHMENT C

ELIGIBILITY VERIFICATION

In order to provide the best possible service please complete all information in detail.

This form is to be completed by the EMPLOYER

A-EMPLOYEE SECTION

EMPLOYEE NAME: EMPLOYEE SS NUMBER: EMPLOYEE DATE OF BIRTH : EMPLOYEE DATE OF HIRE: ORIGINAL DATE OF INSURANCE: WORK STATUS: LAST DATE EMPLOYEE REPORTED TO WORK: RETURN TO WORK DATE:

B-CLAIMANT SECTION

CLAIMANT NAME: CLAIMANT DOB: RELATIONSHIP TO EMPLOYEE: (ie. -spouse,child,other) EFFECTIVE DATE OF COVERAGE: OTHER INSURANCE:Yes No

C-CLAIM INFORMATION

HAS EMPLOYMENT BEEN TERMINATED? Yes No IF YES, PLEASE GIVE DATE AND REASON:

IS COBRA APPLICABLE? Yes No IF SO, PLEASE PROVIDE EFFECTIVE DATE:

(If yes, please attach the election form and supporting documentation of paid premiums. Verification of other insurance may be needed for COBRA recipients.)

REGARDLESS OF CLAIMANT, PLEASE INDICATE ANY DATES THE EMPLOYEE WAS ABSENT DURING THIS CLAIM PERIOD. SPECIFY THE DATES OF EACH ABSENCE AND HOW ELGIBILITY WAS MAINTAINED:

Table with 4 columns: Description, From, To, Total Time Used. Rows include Sick Leave used, Vacation Time used, FMLA, and Other.

Additional Comments: (If any additional time is taken during plan year, other than stated above please advise.)

IF THE EMPLOYEE HAD NO ABSENCES DURING THE REPORTED CLAIM PERIOD, PLEASE CHECK HERE:

IS EMPLOYEE OR CLAIMANT ELIGIBLE FOR MEDICARE? Yes No (If so, please submit a copy of their Medicare card.)

D-GROUP INFORMATION

I CONFIRM THE ABOVE INFORMATION IS ACCURATE AND CURRENT.

EMPLOYER SIGNATURE: TITLE: NAME OF GROUP DATE: NAME GROUP ADMINISTRATOR

**PLEASE NOTE THIS FORM IS TO BE COMPLETED BY THE EMPLOYER AND SUBMITTED WITH A COPY OF THE ENROLLMENT CARD.

ATTACHMENT D

Aggregate Claim Reimbursement Request

This form must be completed in full with ALL submissions.

TPA Name: _____ Phone #: _____

Address: _____

Group Name: _____ Policy Year: From _____ To _____

Carrier Group Number: _____ Incurred/Paid Basis _____

Total claims paid: _____

Less Refunds, Reimbursements and Voids: (_____)

Less Charges Paid Outside Plan Year: (_____)

Less Charges Not Eligible for Aggregate Reimbursement: (_____)

Specific Stop Loss Claims Paid or Pending: (_____)

Attachment Point: (_____)

Requested Reimbursement: _____

Minimum Attachment Point: (if applicable): _____

Attachment Point Factors:

_____ Single
_____ Composite

_____ Family
_____ Other

Enrollment Numbers:

Month	Year	Single Count	Family Count

Month	Year	Single Count	Family Count
Total:			

Required Documents:

- Eligibility listing showing all employees covered during plan year. The report should provide employee name, effective date and termination date and type of coverage elected
- Paid claim report for plan year showing subtotals by claimant as well as total benefits paid refunds, and voids
- Documentation of any voids performed or refunds performed that were received after end of plan year that applies to claims paid during the policy period
- Documentation of any outstanding overpayments
- Bank statements of claim funding information during plan year
- If applicable, copies of drug card invoices from which the prescription drug card payments were issued and the date of such payments

Completed by:

Name _____ Title _____ Date: _____

Send to: Claims Dep't, RMTS, LLC, 6 Harrison St., NY, NY 10013
212-925-8760 (fax) / 212-925-0017 (phone)

IMPORTANT NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The following also applies if your policy is issued in:

ARIZONA: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.